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ABSTRACT

This report describes an attempt to implement a cost-effective social learning intervention program for home use in which behavior modification techniques were taught to parents of 12 conduct-problem children (ages between 3 and 11 years) by psychologists at the Children's Hospital of Eastern Ontario. Mother and father and mothers-only treatment groups plus a control group were formed. Six families participated in each group. Core features of the intervention were the rating of the child by parents and teachers, the teaching of social learning principles to parents, teaching parents how to pinpoint and chart behavior problems, and establishing parent-child contracts involving behavior rewards and punishers. Each family in a treatment group spent an average of 11.5 hours in treatment. Comparisons of pre-treatment, post-treatment and follow-up data from behavior rating scales were made. Extension of the home intervention to school settings was attempted with 4 children. Significant decreases in problem behaviors were reported on behavior rating scales completed by parents in the treatment groups compared with controls. The children in the mothers-only and mother and father groups fared equally well. Follow-up data revealed that these positive changes were maintained. Means of teacher ratings of treatment groups were in the direction of improved behavior, but no generalization of affects can be made. (Author/RH)

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Are Fathers Necessary in Parent Training Groups?

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Behavior modification techniques were taught to the parents of 12 conduct-problem children. Although both parents were willing to come to the training sessions, one group involved training mothers-only while the others were seen in two-parent groups. Significant decreases in problem behaviors were reported on behavior rating scales completed by parents in the treatment groups compared with waiting list controls. The children in the mothers only and two-parent groups fared equally well. Four month follow-up data revealed that these positive changes were maintained. However, at no point was there generalization to classroom behavior.

A major development in child clinical psychology in the last decade has been the increasing emphasis placed on reprogramming the social environment of children designated as "conduct problem." While social learning theorists have long stressed the importance of changing the social environment to change behavior (Bandura and Walters, 1963; Ullman and Krasner, 1969), effective training programs for teaching parents to become the therapists or agents of change for their children have only recently been developed (Bernal, 1972; Patterson, Cobb and Ray, 1973; Patterson, Reid, Jones and Conger, 1975). The effectiveness of this type of therapeutic approach has been demonstrated by investigations carried out with the parents of aggressive, antisocial and delinquent children (e.g. Patterson et al., 1973; Wiltz, 1974; Bernal, Note 1; Berkowitz and Graziano, 1972).

To date, however, to a large extent, the studies reporting success with such programs have been conducted in research or university settings and have required more resources, especially in terms of personnel, than are usually available in applied clinical situations. For example, the program presented by Patterson et al. (1975) to train parents to alter the behavior of their child requires not only close supervision of parents by home visits and frequent telephone contacts, but also specifies that therapists go into the school to design and direct behavioral programs to alter deviant classroom behavior. One concern might be that the average practicing

clinician who has to function without assistants would find these demands on his time and energy too great to conduct such programs, although many of the children referred to him for treatment would benefit from this therapeutic approach.

The present report describes an attempt to implement a social learning intervention in a psychology department of a children's hospital, using only the resources normally available to the staff. Basically, the intervention procedures were adopted from Patterson et al. (1975) with the following modifications: All parent supervision was done in the hospital during regular weekly sessions with no home visits, regular school visits or telephone contacts being made. Finally, given the nature of the government medical care system in the province, virtually all health services are free, thus no monetary deposits or fees were instituted.

Because they are freer during the hours that therapists work, mothers only rather than both parents have typically been involved in investigations concerned with evaluating the effectiveness of parent training programs (e.g. Glogower and Sloop, 1976; Bernal, 1969; Bernal, 1972). An exception to this is a report by Martin (1977) who found that a brief family intervention involving training in conflict resolution and contingency management was effective in reducing the rate of problem behaviors regardless of whether both parents or mothers only were involved. Another purpose of the present study was to assess the efficacy of contingency

management with both parents as compared to mothers only. The implications of the results might be particularly relevant when making the decision to operate parent training groups as standard intervention procedures.

METHOD

Subjects

The subjects in the present study consisted of the parents of 31 male children aged between 3 and 11 years. A total of 18 of these 31 subjects accepted and completed the investigation. The children were referred to the Children's Hospital of Eastern Ontario by physicians, who reported such behavior problems as aggression, noncompliance, temper tantrums, etc. Table 1 describes the populations that completed this investigation (Quay and Peterson, Note 2).

Since the therapy groups were conducted sequentially, parents were assigned to groups as the children were referred, with the first six parents participating in the parent group, the next six mothers participating in the mothers group. The parents of an additional six children constituted the waiting list control subjects who were provided with treatment after a four month delay.

For all subjects, the selection criteria included: (a) children were living at home with two parents, (b) children and parents were not obviously mentally retarded or psychotic, (c) for the mothers groups, it was clear that the fathers would cooperate with the mothers. In addition, with one exception, no children were taking psychotropic medication.

Rating Scales

Before intervention was started both parents and teachers of the children completed the Behavior Problem Checklist (BPCL: Quay and Peterson, Note 2) in order to get a profile of the children involved.

Insert Table 1 about here

A pilot study had indicated that the BPCL was sensitive to behavioral intervention when parents were the raters, but not teachers and that Conners Teacher Rating Scale (CTR: Conners 1969) was sensitive when used by teachers but not by parents. Thus in the present study, teachers were required to complete the CTR and parents the BPCL, prior to and after intervention. Only the Conduct Problem and Personality factors of the BPCL were analyzed since the other factors have been found to be unreliable (Quay and Peterson, Note 2). In addition, a four month follow-up was conducted on the children in the treatment groups. Ethical considerations required that children in the control group be provided with treatment hence a similar control follow-up is not available.

Procedure

A behavioral approach to management of problematic behaviors, modeled after the social learning program described by Patterson et al. (1975) was used throughout both groups and all sessions. Because of restrictions in the number of therapists and hours

available for the project, the Patterson procedure was modified in several ways: (a) no home visits or observations were conducted, (b) school visits were minimal, averaging two hours per treatment group, (c) parents acted as colleagues in discussions with teachers and in developing behavioral contingencies and contracts with the teacher for the child, (d) each group was led by two therapists - a post-doctoral and pre-doctoral psychology intern under the supervision of a staff psychologist.

Intervention

Step 1

The entire family of the referred child was invited to the initial interview. At this time, developmental and background information was obtained, as well as a clinical impression of the problem with the referred child. If the family, and particularly the parents, seemed to possess the cohesiveness to work together, and if the selection criteria were met, the experimental goals and nature of the group training project were explained to the parents and they were invited to participate. Those parents who accepted the group intervention were then asked to independently complete the BPCL. The CTR were obtained at the same time.

Step 2

The parents were now introduced to, and held responsible for understanding social learning principles. Families: Applications of Social Learning to Family Life (Patterson, 1971) was given to

the parents to read. A test on the contents of this book was administered two weeks later to assess the comprehension of parents. Additional instruction was given where needed. At this time the subjects were assigned to the mothers-only or two-parent groups. In the mothers-only groups, fathers did not come in for further sessions. The parents were also taught to pinpoint one or two behaviors of highest frequency and of major concern (non-compliance and aggression were the most common). Having clearly defined such behaviors, parents were then taught to chart the occurrence of these behaviors on a daily basis. On every subsequent visit, these charts were submitted for inspection. Frequency graphs for each behavior were prepared to provide a long-term visual record of the target behaviors. Steps 1 & 2 usually covered four sessions.

Step 3

After successful completion of Steps 1 & 2, parents began with group meetings during which child behavior rewards and punishers were discussed. Parent-child contracting was introduced as well, with nearly all cases being conducive to such a procedure. The first contract was modelled by the therapists, with subsequent contracts being negotiated and constructed by the family. Throughout the sessions the weekly charts were being presented and discussed. Individual contingencies were instituted or altered where necessary. A punisher employed by most parents was timeout. Being a very potent tool, close control of how parents used timeout was maintained.

Behavioral charts and parental reports indicated that this procedure effectively reduced inappropriate behaviors (repeated non-compliance, aggression, temper tantrums). Contracts very often involved token stars and charts, stars being earned contingent upon specified desirable behaviors and being cashed in for terminal reinforcers.

Step 4

The final four group sessions adopted a problem-solving orientation. Although group participation was always encouraged, group members were particularly encouraged to offer suggestions and opinions in these later sessions. For the final two group sessions, a first attempt at school intervention was undertaken with four subjects. Parents were instructed regarding the nature of their children's behavior in school and counselled on how to get along with teachers and to introduce behavioral interventions in school settings. Contracts and charts similar to those used in the homes were instituted by the teachers with the assistance of the parents. Weekly contacts between teachers and parents in addition to daily charts, were set up. Throughout, the parents acted as behavioral counselors to the teachers, reporting to the group weekly and obtaining advice and encouragement from the therapists and other group members.

Step 5

When it became evident that parents were well versed in the behavioral principles involved and were able to take the initiative to adopt contingencies independently, the group sessions were

terminated. For the final meeting, the husbands of the mothers in the two mothers-only groups were invited back. For all parents in all groups, the behavior rating scales were again completed, and scales were obtained from teachers. In addition, arrangements were made with the parents to obtain the same data after four months.

RESULTS

Of the 25 families who met the criteria and were offered treatment, only 12 completed treatment. Nine families refused treatment outright. Generally these parents suggested that their child was not too serious a problem and they could manage themselves. The remaining four families dropped out within the next three sessions and before the group sessions commenced. Once group meetings began, all subjects participated to termination. There were thus six subjects in each of the treatment groups and the childrens ages did not differ significantly ($\bar{x}=7.6\pm1.94$).

Due to illness or lack of cooperation by parents and teachers there is missing data. Nevertheless, 82% of the raters (mothers, fathers, teachers) responded to the four month follow-up and each child had follow-up ratings provided by at least one of the raters.

Since follow-up data was not available for the control group two analyses were undertaken. One analysis considered only the pre- and post-measures with the three groups (Figures 1 and 2).

Insert Figures 1 and 2 about here

The second analysis considered only the treatment groups in order

to assess whether any changes occurring during treatment were maintained.

Parent Ratings

An analysis of variance (group x time x rater) on the Conduct-Problem factor resulted in a significant time effect $F(2,15)=10.02$, $p<.01$ and a time x group interaction $F(2,15)=4.42$, $p<.05$. Multiple t-tests (α adjusted to a .01 level) revealed that both treatment groups improved compared to the control group but that only the two-parent groups showed a significant decrease in problematic behavior after therapy. The analysis on the Conduct-Problem factor including the follow-up and excluding the control group revealed a significant time effect $F(1,15)=6.09$, $p<.05$ showing that for both groups post- and follow-up scores were reliably lower than pre-test scores but were not different from each other.

The analysis of variance on the Personality factor produced a reliable rater effect $F(1,14)=10.72$, $p<.01$ indicating that fathers tended to rate children as less problematic than mothers (Table 1). In addition, the significant group x time intereaction $F(2,15)=9.60$, $p<.01$ showed that the two treatment groups improved compared to the control groups, although only the mothers group had a significant pre-to post-improvement in scores. The analysis of variance including the follow-up data also resulted in a significant time effect $F(1,15)=6.70$, $p<.01$ indicating that both groups were significantly improved after treatment and this improvement was maintained at follow-up.

Teacher Ratings

Analyses of variance conducted on each of the four factors of the CTR resulted in no significant effects. It is interesting to note, however, that all means were in the direction of improved behavior in the two treatment conditions and not in the control group.

Contact Hours

Each family spent an average of 11.5 hours in treatment. In addition, a total of eight hours was spent by the therapists in school visits for selected children across the treatment groups.

DISCUSSION

The results of the present study carried out in a clinical setting are at once encouraging and discouraging. It appears that, with parents as reporters, the intervention utilized was quite successful in increasing appropriate behaviors at home. Conceivably a waiting list control group is inappropriate for the type of therapy being evaluated and the findings are spurious, due to a placebo effect. However, studies investigating similar interventions, using more appropriate pseudo-treatment controls have achieved similar results, attenuating this alternative (Martin, 1977; Walter and Gilmore, 1973).

It appears that fathers' attendance in treatment may not be necessary for behavior change at home to take place. There are several alternative explanations for this. It is possible that in

both therapy groups mother does all the work with the child and hence dad's participation is of secondary importance. Another explanation would be that in the mothers-only groups, mothers become effective teachers and pass on their newly-acquired skills to fathers, either directly or through modeling. The final consideration addresses itself to the necessity of mothers in this type of intervention. Perhaps any one parent would be sufficient to affect positive change in the home behavior of children.

Significant behavior change in the school was not affected by the intervention. This is discouraging, yet at the same time not surprising. Although many studies do not attempt to assess the generalization of treatment effects, those that do have amply documented the specificity of behavior change. In fact, several investigations have addressed themselves to the need for programming generalization in behavior change (Patterson et al. 1973; O'Leary and Drabman, 1971). The clinician in a hospital setting often has severe time and resource limitations and hence avoids costly school vists. The present research suggests that unless this is undertaken, behavior change in the school probably will not occur. Towards the end of the present study when it became apparent that school behavior was not being affected, contracting by the parents and teachers with four children was initiated (see Method section). With each of the children treated in this fashion, teachers reported a considerable improvement on the CTR, but the small numbers involved precluded statistical analysis.

The published research to date includes many examples of individual and group interventions similar to the ones used in the present study. Almost invariably these demonstrations are undertaken in research or educational settings, often to demonstrate the efficacy of a certain technique. However, they rarely allow for generalization to the clinical settings in which the greatest amount of treatment takes place. For example, often the clinical effectiveness of treatment is demonstrated on small numbers of children (4-6) and authors do not indicate how many individuals were screened in order to find cooperative clients. It is suggested that clients who fit the criteria for inclusion into these treatment studies, but refuse after a description of the intervention is made available be considered in the attrition rate. The clients who remain are a select group due to motivational and attitudinal characteristics. In addition, papers often do not adequately describe their subjects utilizing well known assessment devices and one suspects that these populations may differ from hospital populations (especially when participants are sometimes solicited through advertisements and/or are largely children of university faculty or students).

Nevertheless, the present research was undertaken to assess the efficacy of the parent training approach in a hospital setting with a regular hospital clientele. The patient profile (Table 1) suggests that the children were rather severe behavior problems and that the intervention was successful in changing problematic

behavior in the home in a relatively affordable fashion. However, if behavior change outside the home is required the implementation of other forms of intervention and/or different techniques to ensure generalizability may be necessary.

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TABLE 1

Mean Pretest Scores on Peterson-Quay Checklist for all Three Raters in all Three Groups

P.Q. Factor	Rater								
	Mother			Father			Teacher		
	Group			Group			Group		
	1	2	3	1	2	3	1	2	3
Conduct Problem	14	12	14	12	12	13	11	9	11
Personality Problem	6	6	5	4	4	3	4	7	5
Immaturity	2	2	3	1	2	2	2	5	4
Socialized Delinquency	0	0	0	0	0	0	1	0	0

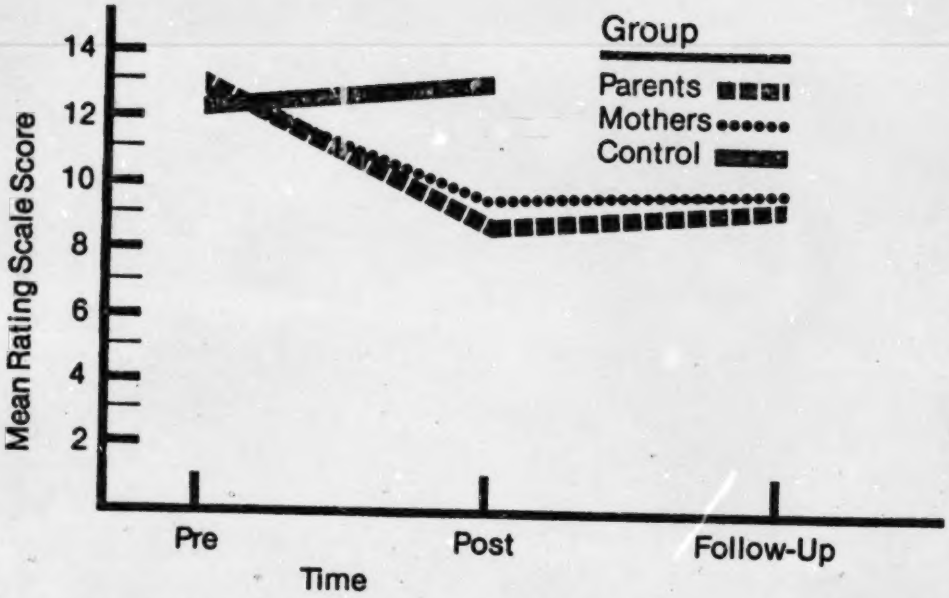

Figure 1. Mean Conduct Problem Scores Across Treatments And Time

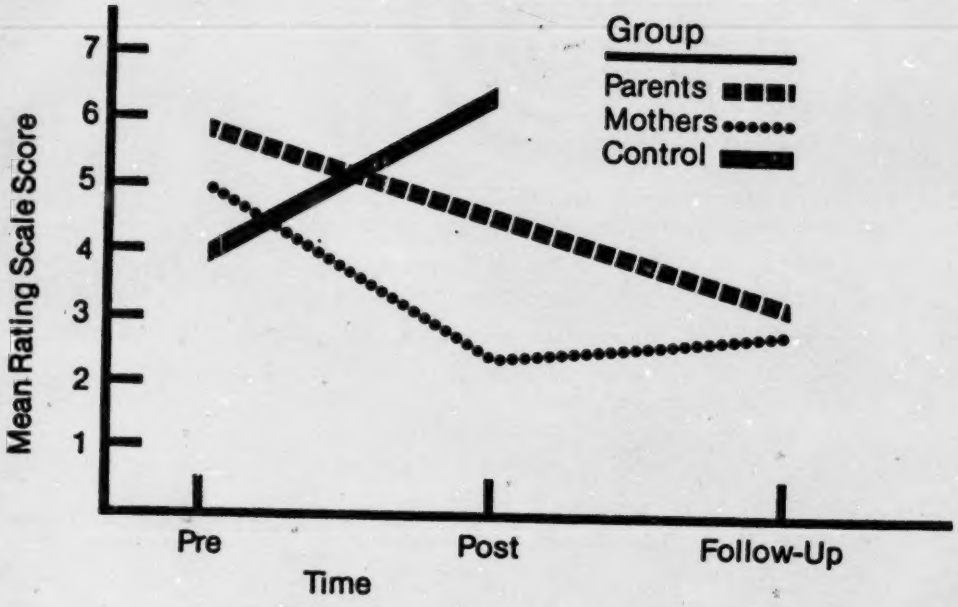

Figure 2. Mean Personality Problem Scores Across Treatments and Time